NA 04-0233-C H/H Steves v Barnhart
Judge David F. Hamilton Signed on 1/9/06

NOT INTENDED FOR PUBLICATION IN PRINT

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF INDIANA
NEW ALBANY DIVISION

JUDY L. STEVES,	)	
	)	
Plaintiff,	)	
vs.	)	NO. 4:04-cv-00233-DFH-WGH
	)	
JO ANNE B.	)	
BARNHART,COMMISSIONER OF THE	)	
SOCIAL SECURITY ADMINISTRATION,	)	
	)	
Defendant.	)	

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF INDIANA
NEW ALBANY DIVISION

JUDY L. STEVES,	)	
	)	
Plaintiff,	)	
	)	
v.	)	CASE NO. 4:04-cv-0233-DFH-WGH
	)	
JO ANNE B. BARNHART, Commissioner of the Social Security Administration,	)	
	)	
Defendant.	)	

ENTRY ON JUDICIAL REVIEW

Plaintiff Judy L. Steves seeks judicial review of a final decision by the Commissioner of Social Security denying her application for disability insurance benefits. Acting for the Commissioner, an Administrative Law Judge ("ALJ") determined that Ms. Steves was not disabled under the Social Security Act because she retained the residual functional capacity to perform a limited range of semi-skilled sedentary work. As explained below, the ALJ's decision is supported by substantial evidence and is therefore affirmed.

Background

Ms. Steves was 49 years old in 2004 when the ALJ found her ineligible for disability insurance benefits under the Social Security Act. R. 16. Ms. Steves has

her high school equivalency diploma or GED. R. 123. In the past, she has worked as a tanning bed salon worker, grocery store cleaner and cashier, quality control inspector, candle wrapper and shipper, prep cook, and restaurant owner and operator. R. 36-39, 118. Ms. Steves claimed to have suffered from stroke, arthritis, fibromyalgia, upper and lower back pain, numbness on her left side, breathing problems, and a bulging disc. R. 117. She claimed that these impairments disabled her, within the meaning of the Social Security Act, after May 7, 2002. R. 126.

Ms. Steves has twice previously applied for disability benefits – on July 15, 1998 and April 25, 2000. R. 89. Both of these applications were denied initially and upon reconsideration, and the denials were affirmed by an ALJ. See R. 73, 89. Neither decision was appealed to the district court.

Ms. Steves' alleged onset date of May 7, 2002 for this third application represents the day after the ALJ's final decision on her second application for benefits. See R. 86-97. Ms. Steves does not argue that the ALJ in this case reopened her previous disability determinations under 20 C.F.R. § 404.988 or 404.989, so she is required to show that she became disabled after May 7, 2002. See *Campbell v. Shalala*, 988 F.2d 741, 745 (7th Cir. 1993) (refusing to reconsider ALJ's decision that two previous applications for benefits barred finding of disability prior to date on which claimant's second application was rejected);

Rucker v. Shalala, 894 F. Supp. 1209, 1217-18 (S.D. Ind. 1995) (discussing preclusive effect of earlier disability determination).[1]

In addition, Ms. Steves' insured status expired on December 3, 2002. R. 24, 126. Accordingly, she must establish that she became disabled on or before this date to recover disability insurance benefits, as distinct from supplemental security income. See 42 U.S.C. § 423(a)(1)(A), (c)(1); 20 C.F.R. § 404.131; *Briscoe v. Barnhart*, 425 F.3d 345, 352 (7th Cir. 2005) (ALJ properly considered whether claimant's impairments rendered him disabled prior to expiration of insured status); *Stevenson v. Chater*, 105 F.3d 1151, 1154 (7th Cir. 1997).

The record contains information about Ms. Steves' medical history from late 2000 until late 2003. Because of her previous disability applications and expired insured status, much of this evidence falls outside of the relevant disability onset period. Nevertheless, the court summarizes the full record here since it is helpful for understanding the background and progression of Ms. Steves' health problems. *E.g.*, *Reynolds v. Bowen*, 844 F.2d 451, 454 (7th Cir. 1988) (noting that ALJ discussed prior proceedings "only to describe the claimant's background and not to review their merits").

[1]At the hearing, the ALJ expressly stated that he was not reopening either of Ms. Steves' previous disability determinations. The ALJ also urged Ms. Steves' counsel to focus his questioning of Ms. Steves on the time after her second disability determination (*i.e.*, May 2002 forward). See R. 54-55.

Ms. Steves was seen at the Cobbler Station Family Clinic ("Clinic") for a variety of complaints from June 2000 through August 2002. See R. 227-83. Based on Clinic records, and the records of referral physicians, it appears that Ms. Steves' primary treating physician at the Clinic was Dr. Mohammed. Compare, *e.g.*, R. 274 and R. 165; R. 278 and R. 164.

On June 8, 2000, Ms. Steves visited the Clinic and complained of depression manifested as feelings of anger, wanting to sleep all of the time, and pain all over. R. 281. Dr. Mohammed noted "mood abnormal, tearful, flat affect," and diagnosed depression. R. 282. Ms. Steves reported having taken Zoloft previously but stopped taking it when she felt better. R. 281. Dr. Mohammed listed her medications as Zoloft, Zyrtec, Synthroid, and Prilosec. He also recommended that she exercise and quit smoking. R. 282.

In July 2000, Dr. Mohammed referred Ms. Steves, R. 277-80, to Dr. Patel, an otolaryngologist, for the sudden onset of a hoarse voice, and coughing and choking spells. R. 164. Dr. Patel prescribed Duratuss and Vanceril and discharged her from his care. *Id.*

In October 2000, Ms. Steves visited the Clinic for multiple symptoms, including back pain radiating from both sides and a headache behind her eyes. R. 273. Dr. Mohammed noted in his records that he had observed Ms. Steves getting out of her car without difficulty. *Id.*

Also in October 2000, Ms. Steves reported hip and lower back pain and numbness to Dr. Ignacio of Southern Indiana Neurology Associates. R. 298. The doctor's notes indicated that she had been diagnosed with fibromyalgia and was undergoing physical therapy. *Id.* In December 2000, Ms. Steves came in for a re-evaluation and complained of continued episodes of left-sided numbness, which Dr. Ignacio attributed to a lacunar infarct in her right thalamus. R. 297. A lumbar spine x-ray was negative. *Id.* Dr. Ignacio conducted a physical capacity evaluation which he said showed that Ms. Steves could withstand only about 3 to 4 hours of work per day, provided she could stay in one position for quite some time. *Id.* He stated that she could sit for 3 hours, and walk and stand less than 1 hour. *Id.* He found no problems with hand manipulation or repetitive movement of her legs, but observed difficulty squatting and crawling. *Id.* Dr. Ignacio concluded that Ms. Steves was unable to perform any gainful employment at that time. *Id.*

Ms. Steves repeatedly reported cough and sinus problems to the Clinic from November 2000 until April 2001. R. 259-60, 263-64, 269-70, 271-72. She was advised on each occasion to drink plenty of fluids and to stop smoking. *Id.* In January 2001, Ms. Steves visited the Clinic complaining of upper back pain radiating into her arms. R. 267. Dr. Mohammed noted a diagnosis of fibromyalgia. R. 268.

Ms. Steves has a history of peripheral vascular disease and complaints about pain caused by poor circulation in her legs. In February 2001, she complained of back pain and tingling and numbness in her legs. R. 265. Dr. Mohammed referred Ms. Steves to Dr. Self of Thoracic Vascular Associates, who oversaw several tests and procedures. On March 1, 2001, Ms. Steves underwent an ankle/brachial indices ("ABI") examination to determine the cause of her "decreased dorsalis pedis pulses" and the pain she was experiencing in her left leg and buttocks. R. 167-68, 205. The test revealed an abnormal ABI in her left leg, so the physician then performed a duplex interrogation of her left lower leg arterial system. *Id.* The results of that test did not suggest single segment disease, but it was thought that additional tests were needed. *Id.* At that time, Dr. Self stated that he did not believe all of Ms. Steves' symptoms, including the pain in her legs and hips, could be explained by her vascular disease. R. 206.

On March 30, 2001, an arteriogram of Ms. Steves' legs revealed high grade stenosis in her left common iliac artery and some narrowing in the proximal right common iliac artery. R. 189, 204. On April 26, 2001, Ms. Steves underwent a balloon angioplasty and a stent was placed into her left common iliac artery which was successful in eliminating stenosis in that leg. R. 186-88. About one month later, Ms. Steves underwent a balloon angioplasty of her right iliac artery which successfully repaired flow through that artery. R. 179-81, 202. Following this procedure, in June, Ms. Steves reported to Dr. Self that her walking was gradually improving. R. 201. By August 2001, Dr. Self reported that Ms. Steves was "able

to walk a mile or two before having to stop." R. 200. He noted that she continued to have pain in her right ankle, but he believed it might be attributable to her recent diagnosis of fibromyalgia and suggested that she follow up with her rheumatologist. *Id.* On January 7, 2002, Dr. Self reported that Ms. Steves' peripheral vascular examination was normal. R. 212.

In June 2001, Ms. Steves visited Dr. Mallampalli for a pulmonary consultation because she was still experiencing a persistent cough. Dr. Mallampalli concluded that her underlying problem could be asthma, gastroesophageal reflux disease, or post-nasal drip. R. 193-95. He prescribed an inhaled steroid. *Id.* Dr. Mallampalli also noted that Ms. Steves was treating her existing gastroesophageal problems with Prilosec. *Id.*

Ms. Steves continued to visit the Clinic nearly every month during 2001. In June 2001, she complained of a constant dry cough and that one side of her face appeared to be drooping. R. 255. On July 9, 2001, she complained of pain in her upper abdomen. The treating physician noted that her abdomen was tender all over and that her pain worsened when she sat up. R. 253-54. On July 30, 2001, she visited the Clinic and complained of the same cough for which she had seen Dr. Mallampalli. R. 251. Ms. Steves also complained of pain in her left shoulder, and that movement of her arm was painful. *Id.*

In September 2001, Ms. Steves visited the Clinic with complaints of back, buttocks, neck, shoulder, leg, and hip pain. R. 249. Dr. Mohammed observed tenderness over her shoulder muscles and referred Ms. Steves, R. 250, to Dr. Campbell at the Spine Institute for her back and leg pain. R. 208-10. Dr. Campbell noted that Ms. Steves had previously been diagnosed as having a mildly desiccated disc in her back. R. 208, 209. In her October visit, Dr. Campbell reported that Ms. Steves was experiencing 75% back pain and 25% leg symptoms. R. 209. He noted that Ms. Steves was "alert and oriented times three," did "not appear in any acute stress," and that her motor strength was good and sensation was intact. *Id.* Dr. Campbell placed Ms. Steves on different pain medication and Ultram, a pain reliever. R. 209-10. In November, Dr. Campbell noted that Ms. Steves continued to have back and buttock pain, and that the pain medication had not improved her symptoms. R. 208. He put her on Celebrex and a muscle relaxant, hoping to see improvement. He believed surgery was not an option. *Id.*

Ms. Steves visited the Clinic throughout late 2001 and early 2002, complaining of symptoms like coughing, frontal headaches, neck stiffness, persistent nausea, and sinus problems. See R. 239, 241, 243, 245, 247. Dr. Mohammed recorded in October 2001 that Ms. Steves was not using her inhalers. R. 247. He listed her diagnosis as some variation of bronchitis/sinusitis/post-nasal drip and suggested that she stop smoking. R. 240, 242, 244, 246, 248.

On May 20, 2002, Ms. Steves saw the Clinic for lower back pain, and Dr. Mohammed noted tender muscles and some distress with walking. R. 233-34.

Ms. Steves filed her current application for disability insurance benefits on May 31, 2002, alleging that she had been disabled since May 7, 2002. R. 111-13. As part of her May 31, 2002 application, Ms. Steves completed a disability report listing her conditions and symptoms. She reported disability due to stroke, arthritis, fibromyalgia, upper and lower back pain, numbness on her left side, breathing problems, and a bulging disc. R. 117. Soon thereafter, she completed a daily activities questionnaire in which she identified back and leg pain and breathing problems as the primary causes of her limitations. R. 131-34. She also stated that she would "get upset and sometimes cry" when her husband and mother criticized her cooking, and that she felt nervous when driving far or when worrying that she might be late for an appointment. *Id.* Her activities report was consistent with an activities report completed by her husband. See R. 136-40.

Ms. Steves visited the Clinic again in June 2002, complaining of sharp epigastric pain that interfered with her sleep. R. 231-32. Dr. Mohammed referred her to a gastroenterologist, Dr. Strobel. R. 300-01. Dr. Strobel noted that, upon general examination, Ms. Steves was an alert, pleasant, comfortable woman in no acute distress. R. 301. He stated his impression that Ms. Steves suffered from gastroesophageal reflux disease. He recommended that she take Zantac and

undergo an EGD to look for erosive esophagitis. *Id.* There are no additional notes by Dr. Strobel in the record.

In July 2002, Ms. Steves visited the Clinic for lower back pain radiating into her leg and Dr. Mohammed noted tender muscles. R. 229-30. Her last recorded visit to the Clinic was August 5, 2002, when she complained of numbness on her left side. R. 227. While most of the text from these records is missing, it appears that Dr. Mohammed suggested Ms. Steves see a neurologist as soon as possible. R. 228.

Ms. Steves was seen by Dr. Joassin for a consultative examination on July 20, 2002. R. 221-25. Ms. Steves reported to Dr. Joassin about constant pain in her lower back, sometimes radiating into her thighs, and exacerbated when standing, pushing, pulling, or lifting. R. 221. She also reported having suffered two strokes and subsequent mini-strokes, resulting in occasional episodes of slight numbness. *Id.* Dr. Joassin described Ms. Steves as "alert, awake and in no acute distress." R. 222. He observed that she was able to get on and off of the examination table without difficulty or assistance. *Id.* Dr. Joassin stated that Ms. Steves suffered from a slight limp, but that her station and gait otherwise showed no apparent distress. R. 223. Although she was somewhat unsteady standing on her toes and heels, he found no limitation in the range of motion of her spine or extremities. *Id.* Dr. Joassin rated her motor strength at 5/5 on her right side and 4/5 on her left side, and her hand grip at 5/5 in the

right hand and 4/5 in her left hand. *Id.* He observed that she hesitated to squat because of pain in her lower back and that she could not stoop. R. 223-24. Dr. Joassin ultimately concluded that his examination of Ms. Steves did "not reveal any significant functional impairment." R. 224.

On August 7, 2002, Ms. Steves was brought to the emergency room for complaints of left-side pain and numbness, bad headaches, and nausea. R. 286. The treating physician's initial impression was that Ms. Steves might have had a new transient ischemic attack (mini-stroke) or stroke, and he cited her multiple risk factors for stroke, including smoking. *Id.* An MRI revealed as the only abnormality a tiny, old, stable lacunar infarct in the thalamic area of her brain. R. 290. A CT scan of the head, an echocardiogram, and a cardiovascular ultrasound all appeared normal. R. 291, 294, 295. Ms. Steves was hospitalized for two to three days. See R. 41, 296.

Following her hospitalization, Ms. Steves visited Dr. Matibag for a neurological examination relating to her left-side numbness. R. 296. Dr. Matibag reported that Ms. Steves appeared awake, alert, and oriented with no gross cognitive dysfunction. *Id.* He rated her motor strength in both hands as 5/5. *Id.* He also observed mild swelling in her left leg, as compared to her right. *Id.* Dr. Matibag primarily noted that Ms. Steves had developed ecchymosis in her extremities, resulting in large bruises after barely bumping herself. *Id.* He therefore recommended no strenuous activities or exercise and that she avoid

heavy lifting or pressure at her susceptible areas. *Id.* He also noted that Ms. Steves had been started on Plavix to prevent future strokes. *Id.*

In September 2002, Ms. Steves visited Dr. Chaudhry for her excessive bruising and prolonged bleeding. Dr. Chaudhry noted "remarkable bruising all over her upper and lower extremities" but his physical examination revealed no other abnormalities. R. 330. Ms. Steves presented no other complaints, and Dr. Chaudhry wrote that her mood and affect were within normal limits and that her pulses were palpable with "no cyanosis, clubbing or pedal edema." R. 331. He noted the same at several follow-up visits. R. 318, 321, 322, 326, 328. Dr. Chaudhry suggested that Ms. Steves decrease her Plavix dosage until her bleeding time decreased. R. 331. Tests failed to reveal any platelet abnormalities. R. 321.

There is additional evidence in the record pertaining to Ms. Steves' mental health. In July 2002, Ms. Steves began undergoing counseling at the recommendation of a consultative examining physician. R. 141, 338. Ms. Steves had several appointments with Ms. Lindsey, a counseling therapist, until the end of 2002. Ms. Lindsey established a therapy plan for Ms. Steves aimed at improving her coping, assertiveness, and communication skills. R. 338. Ms. Lindsey described Ms. Steves' affect and behavior at all sessions as within normal limits. See R. 333-38. She also noted that Ms. Steves was cooperative and exhibited strong eye contact. *Id.*

Ms. Lindsey referred Ms. Steves to a psychiatrist in her office, Dr. Emily Stapp, for a medical/psychiatric evaluation. R. 338. Dr. Stapp saw Ms. Steves in September 2002. R. 335. While Dr. Stapp did not record her own observations of Ms. Steves, she noted that Ms. Steves reported that she had suffered from depression for 18 months and that it had gotten worse over the previous six months. *Id.* Dr. Stapp reportedly discussed options for treating insomnia, anxiety, and depression. *Id.* Her notes indicate that Ms. Steves was taking Ambien, Wellbutrin, and Zoloft. *Id.* Ms. Lindsey's later notes indicate that Ms. Steves had stopped taking her medications by February 2003. R. 333.

On July 3, 2002, Dr. Perry, Ed.D., a licensed counseling psychologist, conducted a mental status consultation examination of Ms. Steves. R. 216-20. When asked by Dr. Perry what type of difficulties might interfere with her ability to work, Ms. Steves discussed her "nagging pain." R. 216. She stated that she had enjoyed working in the past and had gotten along well with others. R. 218. However, Ms. Steves told Dr. Perry that she currently had social contacts with family only, and no longer did anything outside of the house for fun or enjoyment because she did not "feel like getting dressed to go." *Id.* She denied suicidal thoughts but stated "I'd probably be better off dead." *Id.* Ms. Steves reported crying spells, subjective feelings of sadness, and limited energy. R. 219. When prompted to describe her outlook on the future, she stated "I think it will be worse." *Id.*

Dr. Perry observed that Ms. Steves held appropriate eye contact, communicated effectively, and appeared calm and cooperative during his interview. R. 217. He stated that she was clearly oriented to person, place, and time. R. 218. He described her mood and affect as "rather depressed and sad." R. 217. Dr. Perry noted that Ms. Steves "became tearful when discussing her difficulties." R. 218. He found no deficits in either long or short-term memory and stated that her concentration might be mildly impaired. R. 219. Dr. Perry opined that Ms. Steves' subjective feelings of sadness and limited energy were primarily "related to her physical functioning difficulties and pain." *Id.* He stated his belief that she was capable of interacting and communicating effectively with others, such as co-workers or supervisors. *Id.* He stated, however, that Ms. Steves would "likely have some difficulty handling additional stressors such as might be found in work environments at this time." *Id.* He found no evidence of malingering. *Id.* Dr. Perry diagnosed Ms. Steves with "major depression, recurrent, severe" and ranked her on the Global Assessment of Functioning ("GAF") Scale at "50," signifying "serious symptoms of depression." R. 220. He wrote that "her mood is quite depressed and this negatively impacts social functioning (avoidance)." *Id.*[2]

[2]A GAF rating is a mental health rating that estimates a person's psychological, social, and occupational capacities. American Psychological Association, *Diagnostic and Statistical Manual of Mental Disorders* (4th ed. Text Revision 2000). A GAF between 41-50 indicates serious symptoms or serious impairment in social, occupational, or school functioning.

In August 2002, an individual from the Indiana Disability Determination Bureau conducted a phone interview of Ms. Steves to obtain more information about her potential mental impairments. See R. 135, 141-44. The interviewer sought to assess Ms. Steves' concentration and social functioning, and to determine whether her alleged limitations were attributable to mental, as opposed to physical, problems. See R. 284. The interviewer noted that Ms. Steves scheduled her own medical appointments, provided her own transportation to those appointments, and was generally involved in her medical care. R. 142. Ms. Steves reported that "most of the time" she could remember her scheduled appointments, the content of her conversations, and the subjects of television shows she had watched. R. 142-43. Although she got along well with family members, and interacted appropriately with others at the grocery store and pharmacy, Ms. Steves reported that she did not have any friends. R. 143. The interviewer noted that Ms. Steves feels hurt in response to criticism. *Id.* She ate only one meal per day and sometimes had crying spells. R. 144. Ms. Steves claimed that she was depressed because of her physical pain and because "her days are the same day in and day out." *Id.* Ms. Steves identified difficulty sleeping at night, only some of which she attributed to physical pain. *Id.*

On September 5, 2002, two state agency psychologists completed a psychiatric review form about Ms. Steves based on the evidence before them, including Dr. Perry's evaluation. They concluded that Ms. Steves' depression was not severe, finding that her restrictions in daily living, difficulties in maintaining

social functioning, and difficulties with concentration, persistence, and pace were all mild. R. 302, 312. The state psychologists noted that Ms. Steves' treating physicians had not provided any medical opinion regarding functional limitations from depression, and that even Dr. Perry had concluded she was not limited except in her ability to tolerate stress. R. 314. The psychologists wrote that Ms. Steves "appears to perform goal directed activities limited only by [her] physical condition." *Id.*

On September 17, 2002, the Social Security Administration denied Ms. Steve's application for disability insurance benefits, finding that her condition should not prevent her from working. R. 101-04. A request for medical advice by Dr. Gaddy dated September 12, 2002 had stated that Ms. Steves' complaints were "excessive," that she was "partially credible," and that her "physical impairment is not severe." R. 316.

Ms. Steves filed a request for reconsideration on October 31, 2002. R. 105. She also filed a reconsideration disability report, stating that she had suffered a stroke since filing her claim in May, and mentioning Dr. Matibag's instructions that she avoid heavy lifting and strenuous exercise. R. 145-48. Her application was denied upon reconsideration on February 20, 2003. R. 106-07.

From January through October 2003, Ms. Steves' primary care physician was Dr. Beaven. In a physical examination of Ms. Steves on January 14, 2003,

Dr. Beaven recorded abnormal findings of asthma, myalgia, and lumbar and muscle pain. R. 400. He listed diagnoses of asthma, peripheral vascular disease, gastroesophageal reflux disease, and hypertension. R. 397. Dr. Beaven's notes from Ms. Steves' February 17th visit list hypertension, epigastric pain, and depression as the only abnormal physical findings. R. 393-94. On February 21, 2003, Ms. Steves complained of seizures, dizziness, and numbness and weakness in her legs, but a CT scan ordered by Dr. Beaven was normal. R. 389, 405. An MRI was normal, except as it revealed the old stable lacunar infarct in her thalamus. R. 404. An MRA showed Ms. Steves' arteries to be patent. R. 403. Dr. Beaven's notes from February 27th list asthma, a bulging disc, and focal neurological weakness as abnormalities upon examination. R. 386. Dr. Beaven noted that Ms. Steves' pulses were good in her extremities. *Id.*

Ms. Steves filed a request for a hearing before an ALJ on March 3, 2003. See R. 108. She filed a statement along with her request stating that she was experiencing more left-side numbness and lower back pain, which required her to lie down more frequently. R. 149-54.

On March 17, 2003, Dr. Beaven recorded abnormal abdominal pain, lumbar pain, degenerative disc, neurological problems, insomnia, and memory loss. R. 382. Dr. Beaven also completed a physical capacities evaluation of Ms. Steves. He wrote that she could sit only 2 hours per day and could stand/walk 1 hour per day. R. 317. He stated that she could lift no weight and could only occasionally

carry up to 10 pounds. *Id.* Dr. Beaven wrote that she could perform no repetitive movements in her feet and that she could never squat, crawl, or climb. *Id.* He noted that she required moderate restrictions in exposure to dust, fumes, and gases. *Id.*

On March 31, 2003, Dr. Beaven noted emphysema, anxiety, and memory loss, which he appeared to attribute to a previous stroke. R. 380. In May, Dr. Beaven recorded signs of asthma, abdominal pain, excessive bruising, and anxiety. R. 376. An evaluation on June 3rd revealed no abnormalities other than Ms. Steves' stable high blood pressure. R. 372. A June 16th evaluation listed emphysema, tendonitis, and anxiety as Ms. Steves' only abnormal physical findings. R. 369. On June 19, Dr. Beaven listed hypertension and anxiety as his diagnoses. R. 362. On July 10, Dr. Beaven noted that Ms. Steves' extremities responded abnormally to palpitation. R. 356, 360. Twice in July and August, Dr. Beaven recorded findings of both anxiety and depression in Ms. Steves, though he never listed depression as a formal diagnosis. R. 351, 355. On Ms. Steves' last recorded visit to Dr. Beaven, his only findings were that she had asthma/emphysema, seizures controlled by Tegretol, and anxiety controlled by her medications. R. 343. Dr. Beaven noted that her hypertension was much improved with medication, and that her smoking was steadily decreasing. R. 341.

Ms. Steves and a vocational expert testified before ALJ Lawrence E. Shearer on December 18, 2003. See R. 31-69. Ms. Steves was represented by an attorney.

She testified that her back gave her the most pain. R. 53. She testified that she took only a muscle relaxer for pain because the pain medications on top of the muscle relaxer caused her to sleep all day. R. 52-53. Ms. Steves also testified that she sat in a recliner three-fourths of the day with her legs elevated at chest level to prevent pain and swelling. R. 54. Ms. Steves described the residual effects of her stroke (and mini-strokes) as weakness in her legs and arms and memory problems, though she was not sure whether the latter was attributable to stroke or her age. R. 56.

Following the hearing but before a decision was issued, Ms. Steves submitted additional medical information. She submitted a letter from Dr. Beaven, dated December 29, 2003, which stated: "Due to recurrent swelling and peripheral vascular disease, Ms. Steves must keep her feet elevated above her chest/heart level a majority of the time in order to keep down the edema of her lower extremities." R. 406. She also submitted a report by Dr. Self discussing the results of her December 19, 2003 arteriogram. R. 407. He found "mild diffuse atherosclerotic disease of the lower extremities bilaterally without focal stenosis at any level." R. 408-09. The stents in her right external and left common iliac arteries appeared "widely patent with no evidence of recurrent stenosis," although Dr. Self noted generally that her external and internal iliac arteries were "diffusely small" on both sides. *Id.*

The ALJ issued his decision denying benefits on February 27, 2004. See R. 12-25. Because the Appeals Council denied further review of the ALJ's decision, R. 5-7, the ALJ's decision is treated as the final decision of the Commissioner. See *Smith v. Apfel*, 231 F.3d 433, 437 (7th Cir. 2000); *Luna v. Shalala*, 22 F.3d 687, 689 (7th Cir. 1994). Ms. Steves filed a timely petition for judicial review on December 1, 2004. The court has jurisdiction in the matter under 42 U.S.C. § 405(g).

The Statutory Framework for Determining Disability

To be eligible for disability insurance benefits, a claimant must establish that she suffers from a disability within the meaning of the Social Security Act. To prove disability under the Act, the claimant must show that she was unable to engage in any substantial gainful activity by reason of a medically determinable physical or mental impairment that could be expected to result in death or that has lasted or could be expected to last for a continuous period of not less than 12 months. 42 U.S.C. § 423(d). Ms. Steves was disabled only if her impairments were of such severity that she was unable to perform work that she had previously done and if, based on her age, education, and work experience, she also could not engage in any other kind of substantial work existing in the national economy, regardless of whether such work was actually available to her. *Id.*

This standard is a stringent one. The Act does not contemplate degrees of disability or allow for an award based on partial disability. *Stevens v. Heckler*,

766 F.2d 284, 285 (7th Cir. 1985). Even claimants with substantial impairments are not necessarily entitled to benefits, which are paid for by taxes, including taxes paid by those who work despite serious physical or mental impairments and for whom working is difficult and painful.

The implementing regulations for the Act provide the familiar five-step process to evaluate disability. The steps are:

> (1) Has the claimant engaged in substantial gainful activity? If so, she was not disabled.
>
> (2) If not, did the claimant have an impairment or combination of impairments that are severe? If not, she was not disabled.
>
> (3) If so, did the impairment(s) meet or equal a listed impairment in the appendix to the regulations? If so, the claimant was disabled.
>
> (4) If not, could the claimant do her past relevant work? If so, she was not disabled.
>
> (5) If not, could the claimant perform other work given her residual functional capacity, age, education, and experience? If so, then she was not disabled. If not, she was disabled.

See generally 20 C.F.R. § 404.1520. When applying this test, the burden of proof is on the claimant for the first four steps and on the Commissioner for the fifth step. *Young v. Barnhart*, 362 F.3d 995, 1000 (7th Cir. 2004).

Applying the five-step process, the ALJ found that Ms. Steves satisfied steps one and two: she was not currently working and she suffered from the severe impairments of peripheral vascular disease and asthma. R. 24. At step three, the

ALJ found that Ms. Steves failed to demonstrate that any of her severe impairments met or equaled a listed impairment. *Id.* At step four, the ALJ found that Ms. Steves was unable to perform any of her past relevant work. R. 25. At step five, the ALJ found that Ms. Steves retained the residual functional capacity to perform a limited range of sedentary work, so the ALJ concluded that she was not disabled under the Social Security Act. *Id.*

Standard of Review

"The standard of review in disability cases limits . . . the district court to determining whether the final decision of the [Commissioner] is both supported by substantial evidence and based on the proper legal criteria." *Briscoe v. Barnhart*, 425 F.3d 345, 351 (7th Cir. 2005), quoting *Sheck v. Barnhart*, 357 F.3d 697, 699 (7th Cir. 2004). Substantial evidence is "such relevant evidence as a reasonable mind might accept as adequate to support a conclusion." *Diaz v. Chater*, 55 F.3d 300, 305 (7th Cir. 1995), quoting *Richardson v. Perales*, 402 U.S. 389, 401 (1971). To determine whether substantial evidence exists, the court must "'conduct a critical review of the evidence,' considering both the evidence that supports, as well as the evidence that detracts from, the Commissioner's decision . . . ." *Briscoe*, 425 F.3d at 351, quoting *Lopez v. Barnhart*, 336 F.3d 535, 539 (7th Cir. 2003); see also *Zurawski v. Halter*, 245 F.3d 881, 888 (7th Cir. 2001). The reviewing court must not attempt to substitute its judgment for the ALJ's judgment by reweighing the evidence, resolving material conflicts, or reconsidering facts or the credibility of witnesses. *Cannon v. Apfel*, 213 F.3d 970,

974 (7th Cir. 2000); *Luna v. Shalala*, 22 F.3d 687, 689 (7th Cir. 1994). Where conflicting evidence allows reasonable minds to differ as to whether a claimant is entitled to benefits, the court must defer to the Commissioner's resolution of that conflict. *Binion v. Chater*, 108 F.3d 780, 782 (7th Cir. 1997).

A reversal and remand may be required, however, if the ALJ committed an error of law, *Nelson v. Apfel*, 131 F.3d 1228, 1234 (7th Cir. 1997), or based the decision on serious factual mistakes or omissions. *Sarchet v. Chater*, 78 F.3d 305, 309 (7th Cir. 1996). This determination by the court requires that the ALJ's decision adequately discuss the relevant issues: "In addition to relying on substantial evidence, the ALJ must also explain his analysis of the evidence with enough detail and clarity to permit meaningful appellate review." *Briscoe*, 425 F.3d at 351, citing *Herron v. Shalala*,19 F.3d 329, 333-34 (7th Cir. 1994). Although the ALJ need not provide a complete written evaluation of every piece of testimony and evidence, *Schmidt v. Barnhart*, 395 F.3d 737, 744 (7th Cir. 2005), a remand may be required if the ALJ has failed to "build a logical bridge from the evidence to her conclusion." *Steele v. Barnhart*, 290 F.3d 936, 941 (7th Cir. 2002).

Discussion

Ms. Steves raises three discrete challenges to the ALJ's step-five finding that she retained the ability to perform sedentary work. She argues that the ALJ failed to build a logical bridge from the evidence to this finding by (1) ignoring the limitations caused by her depression; (2) failing to adequately articulate reasons

for dismissing her treating physician's opinion that she could not work; and (3) arbitrarily determining that she would not need to elevate her legs as high as chest level for her circulation problems. The court finds that the ALJ's decision is supported by substantial evidence, and that the ALJ adequately articulated his reasons for accepting or rejecting the evidence relevant to his findings.

I. *Depression and Residual Functional Capacity*

Ms. Steves first argues that the ALJ improperly discounted her emotional problems by concluding that her depression did not impose any limits on her residual functional capacity. Ms. Steves does not challenge the ALJ's finding that her depression did not meet or equal the severity of a listed impairment. However, she contends that this finding alone was insufficient to "build a logical bridge" to the ALJ's ultimate conclusion that her depression imposed no limits on her ability to work. Ms. Steves points to Dr. Perry's report from July 3, 2002 as evidence that she suffered from severe depression.

As Ms. Steves recognizes, the ALJ first concluded that her depression did not meet or equal the level of severity of any mental impairment listed in Appendix 1, Subpart P, of Regulations No. 4. See R. 19. The listings for mental disorders are constructed so that an individual meeting the criteria could not reasonably be expected to engage in gainful work activity. Listing 12.00(A). Listing 12.04 applies to the evaluation of affective disorders such as depression.

The ALJ determined that Ms. Steves' depression did not qualify as a severe mental impairment under any of the possible ways of satisfying Listing 12.04. First, the ALJ found that Ms. Steves had not established two of the following: "marked" restriction of daily activities; "marked" difficulties maintaining social functioning; "marked" deficiencies of concentration, persistence, or pace; or three repeated episodes of decompensation, each of extended duration. R. 19. He also found that she had not demonstrated extreme functional limitation in any of these areas. *Id.* Finally, the ALJ found that Ms. Steves had not provided medical documentation that her condition lasted more than two years, causing more than a minimal limitation in basic work activity, and that she had experienced one of the following: repeated episodes of decompensation; a residual disease process resulting in such marginal adjustment that she would be likely to decompensate with minimal change; or a current history of one or more years of inability to function outside a highly supportive living environment, with continued need for such an environment. R. 20.

This step-three analysis was not the ALJ's only consideration of her depression. The listings state that an individual not meeting the listings criteria for mental impairments may nevertheless not possess the residual functional capacity to engage in substantial gainful work activity. See Listing 12.00(A). The listings make clear that the determination of a mental residual functional capacity is therefore crucial when the listings criteria are not met or equaled "but the impairment is nonetheless severe." *Id.*; see also 20 C.F.R. § 404.1520(e) ("If your

impairment(s) does not meet or equal a listed impairment, we will assess and make a finding about your residual functional capacity based on all the relevant medical and other evidence in your case record"); 20 C.F.R. § 404.1545(a)(2) ("We will consider all of your medically determinable impairments of which we are aware, including your medically determinable impairments that are not 'severe' . . . when we assess your residual functional capacity"). Accordingly, the ALJ was required to consider Ms. Steves' allegations of depression in steps four and five when he determined her residual functional capacity and her ability to meet the demands of work.

The ALJ properly considered the potential limits imposed by Ms. Steves' depression and adequately articulated reasons for finding no such limits. First, the ALJ adequately accounted for Dr. Perry's mental status evaluation, noting Ms. Steves' reported feelings of sadness, limited energy, crying spells, and other symptoms of depression, and twice mentioning her GAF ranking of 50. See R. 19, 22. The ALJ acknowledged that Dr. Perry assessed Ms. Steves as having "major depression (recurrent, severe)." R. 19. However, he deemed most relevant that part of the report that found Ms. Steves was oriented to person, place, and time, held appropriate eye contact, and spoke logically and coherently. R. 22. He also noted that Dr. Perry had found Ms. Steves capable of understanding, remembering, and carrying out simple instructions. R. 19. And, as the Commissioner points out, Dr. Perry concluded that Ms. Steves was capable of interacting and communicating effectively with co-workers and supervisors.

Ms. Steves argues that the ALJ mischaracterized Dr. Perry's report by stating that a GAF ranking of 50 indicated "moderate impairment," R. 19, while in fact a GAF of 50 represents either serious symptoms or serious impairment in social or occupational functioning. Although the court must probe mischaracterizations of evidence by the ALJ, *Sarchet v. Chater*, 78 F.3d 305, 307 (7th Cir. 1996), the ALJ's statement here does not rise to the level of those mistakes for which reviewing courts have typically required a remand. Cf. *Golembiewski v. Barnhart*, 322 F.3d 912, 916-18 (7th Cir. 2003) (ALJ's mischaracterization of claimant's MRI results and failure to discuss three significant lines of evidence warranted remand); *Sarchet*, 78 F.3d at 307 ("substantial number of illogical or erroneous statements" demonstrating "pervasive misunderstanding" of fibromyalgia required remand); *Caviness v. Apfel*, 4 F. Supp. 2d 813, 820-23 (S.D. Ind. 1998) (ALJ's failure to consider how lack of resources might affect treatment choices and to properly characterize claimant's daily activities and episodic nature of her alleged impairment required remand).

A GAF ranking of 50 is at the least serious end of the GAF range signifying "serious" impairment (41-50). Further, Dr. Perry's primary basis for assessing Ms. Steves at a GAF of 50 was her social avoidance, *i.e.*, not having any friends outside of the home. Dr. Perry did not draw any conclusions as to how this limitation might negatively affect Ms. Steves' ability to work. In fact, his only findings regarding Ms. Steves' potential for work were that she exhibited a pleasant demeanor, communicated and interacted effectively, but would likely have some

difficulty handling additional stressors in a work environment. In light of the ALJ's discussion of these more specific findings from Dr. Perry's evaluation, the ALJ's mischaracterization of a 50 GAF ranking as "moderate impairment," without more, does not warrant remand.

The ALJ also considered other evidence in rejecting Dr. Perry's opinion about the seriousness of Ms. Steves' depression. Cf. *Rohan v. Chater*, 98 F.3d 966, 970 (7th Cir. 1996) (ALJ improperly disregarded treating psychiatrist's opinion of depression without expressly relying on any other medical evidence or authority). The ALJ noted that Ms. Steves was receiving medical treatment for her depression from Dr. Beaven. R. 22. The ALJ also pointed to the opinions of two state agency psychologists who expressly considered Dr. Perry's report and concluded that Ms. Steves' depression was not severe and would not significantly interfere with her ability to perform work-related activities. *Id.* Under Social Security Ruling 96-6p, the opinion of a state agency psychological consultant may be entitled to more weight if it is within the consultant's area of specialization. In this case, the two agency consultants were doctors of psychology, while Dr. Perry was not.

Of course, under Social Security Ruling 96-6p, the opinions of non-examining sources can be given weight only insofar as they are supported by other evidence in the record. The state consultants' opinions are supported by Dr. Stapp's and Ms. Lindsey's notes, which recorded no significant findings

concerning Ms. Steves' depression. Dr. Stapp was a treating psychiatrist who saw Ms. Steves more recently than Dr. Perry, a consulting examiner. Ms. Lindsey observed Ms. Steves over approximately five-months, as opposed to Dr. Perry's one-time visit, and she found behavior and affect were within normal limits in all visits. The ALJ's conclusion that Ms. Steves' depression did not prevent her from working is also supported by Dr. Mohammed's notes in 2002, which make no mention of her depression, and the notes of the state agent who conducted a telephone interview of Ms. Steves in August 2002.

Finally, the ALJ considered Ms. Steves' testimony at the hearing about her depression and the medications she takes for its treatment. See R. 21. But he concluded generally that her statements concerning her impairments were not credible. *Id.* The ALJ specifically found "nothing in her behavior to indicate strong depression" and concluded that her depression was mild. R. 22. The ALJ stated that although he understood Ms. Steves had some limitations associated with her impairments, he did not find that these limitations precluded all work activity. *Id.*

An ALJ's decision must be based upon consideration of all relevant evidence and must articulate at some minimal level an analysis of that evidence. See *Diaz v. Chater*, 55 F.3d 300, 307 (7th Cir. 1995). In this case, the ALJ discussed Dr. Perry's evaluation, including the aspects indicating that Ms. Steves' depression would not limit her ability to work. The ALJ also articulated his impressions of

Ms. Steves' affect during the hearing and his decision to generally discount her testimony about her impairments, including mental impairments. In light of the other evidence in the record indicating that Ms. Steves' depression was not disabling, the ALJ's finding is based upon consideration of all of the relevant evidence, and he built a "logical bridge" from the evidence to his ultimate conclusion that Ms. Steves' depression did not preclude all work.

II. *Treating Physician's Opinion*

Ms. Steves next challenges the ALJ's decision to discount Dr. Beaven's physical capacities assessment from March 17, 2003. Dr. Beaven concluded that Ms. Steves could sit only two hours per day, stand/walk only one hour per day, lift no weight, carry up to only 10 pounds, perform no repetitive movements with her feet, and never squat, crawl, or climb. R. 317. At the hearing, the vocational expert testified that acceptance of Dr. Beaven's assessment would preclude all jobs for Ms. Steves. R. 67. The ALJ rejected Dr. Beaven's assessment because he found it was "not supported by the objective medical evidence." See R. 18.

Ms. Steves argues that Dr. Beaven was her treating family physician for "a substantial period of time" and tracked her health on a "consistent basis." See Pl. Br. at 11. At the hearing, Ms. Steves testified that she saw Dr. Beaven approximately once a month. R. 41.

A treating physician's opinion regarding the nature and severity of a claimant's medical condition is entitled to controlling weight if well-supported by medically acceptable techniques and not inconsistent with other substantial evidence in the record. 20 C.F.R. § 404.1527(d)(2); *Skarbek v. Barnhart*, 390 F.3d 500, 503 (7th Cir. 2004). However, an ALJ may discount a treating source's opinion if it is inconsistent with the opinion of a consulting physician or if the treating source's opinion is internally inconsistent, as long as the ALJ "minimally articulate[s] his reasons for crediting or rejecting evidence of disability." *Skarbek*, 390 F.3d at 503, citing *Clifford v. Apfel*, 227 F.3d 863, 870 (7th Cir. 2000). Even when a treating physician's opinion does not merit controlling weight, the ALJ must consider the length of the treatment relationship and frequency of examination, the nature and extent of the treatment relationship, the medical evidence supporting the opinion, the physician's specialization in the medical area at issue, and other factors tending to support or contradict the opinion, in determining how much weight to grant the opinion. See 20 C.F.R. § 404.1527(d)(2). An ALJ need not defer to a treating physician's determination of a claimant's residual functional capacity or the ability to perform past or other work. 20 C.F.R. § 404.1527(e)(2); SSR 96-5p.

The ALJ identified substantial evidence supporting his decision to set aside Dr. Beaven's opinion regarding the limiting effects of Ms. Steves' impairments. Dr. Beaven's report was inconsistent both internally and with other evidence in the record. As the ALJ recognized, R. 18, 21, Dr. Beaven's treatment notes showed

that Ms. Steves' condition was stable. Dr. Beaven's records also demonstrated that Ms. Steves presented a variety of ever-changing physical complaints, with hypertension and emphysema as the only consistent diagnoses. Dr. Beaven made no physical findings that would signify serious problems sitting, standing, or walking, other than sometimes noting Ms. Steves' bulging disc. The ALJ also noted, R. 18, that tests performed by Dr. Beaven in February 2003 all came back with normal results. R. 403-05. And Dr. Beaven found that Ms. Steves' pulses in her extremities were good. R. 386. Accordingly, Dr. Beaven's objective medical findings did not support his determination that Ms. Steves could not perform the physical tasks necessary to hold a full-time job.

Most important, the deference typically given to treating physicians does not apply to Dr. Beaven. Although the ALJ did not mention this point, Dr. Beaven's physical capacities evaluation postdates the disability onset period at issue in this case. And Dr. Beaven did not suggest that his March 2003 evaluation related back to the relevant onset period of May through December 2002. Further, although Ms. Steves regarded Dr. Beaven as her treating physician, she had seen him for only six months (no part of which overlapped with the relevant onset period), compared with Dr. Mohammed's treatment of her at the Clinic over a period of two years.

Dr. Beaven's evaluation results were also inconsistent with other medical evidence in the record for the relevant onset period. The ALJ noted, R. 18, that

Dr. Joassin, a consultative examiner, found no significant functional impairments in July 2002. R. 221-24. The ALJ also noted, R. 18, that Dr. Matibag recommended in August 2002 only that Ms. Steves avoid strenuous exercise and heavy lifting. R. 296. Dr. Matibag found mild swelling and good motor strength in Ms. Steves' hands. *Id.* The ALJ pointed out, R. 18, 19, 22, that Dr. Self's records showed a normal peripheral vascular examination in January 2002 and indicated improvement in her circulation problems as late as December 2003. R. 212, 408-09. In several comprehensive examinations at the Clinic during 2002, all findings related to Ms. Steves' lower extremities were normal. R. 227-38. Dr. Chaudhry found her lower extremities had "good muscle tone" and no cyanosis, swelling, or clubbing on at least five separate occasions. R. 318, 321, 322, 326, 330. Thus, Ms. Steves' allegations of swelling that could produce the type of sitting, standing, and walking difficulties recorded by Dr. Beaven are not well-supported by the evidence in the record.

The ALJ rejected Dr. Beaven's evaluation primarily because it was not supported by the objective medical evidence. It was somewhat difficult for the ALJ to elaborate further on this reasoning since it focused on what was missing from Dr. Beaven's records rather than what was present. Nevertheless, the ALJ identified sufficient contrary evidence in Dr. Beaven's own records and the records of other physicians to support his decision to reject the evaluation. His findings, especially when read as a whole, exceed the minimum articulation standard. See

Skarbek, 390 F.3d at 503. Accordingly, Ms. Steves' second challenge to the ALJ's step-five finding must fail.

III. *Leg Elevation*

Finally, Ms. Steves challenges the ALJ's finding that she was not required to elevate her feet above chest level most of the day. At the hearing, Ms. Steves testified that she spends three-fourths of her day in her recliner at home, with her legs elevated as high as the recliner will allow (about chest level). R. 54. She testified that this was necessary to prevent pain and swelling in her legs. The vocational expert testified that this limitation would preclude all jobs. R. 67-68.

The ALJ then asked the vocational expert about available jobs if Ms. Steves was required to elevate her legs only 12-18 inches. *Id.* The expert testified that, if this were the case, Ms. Steves could perform sedentary work. *Id.*

Following the hearing, Ms. Steves submitted a statement by Dr. Beaven dated December 29, 2003 stating that she must keep her feet elevated at chest level to prevent edema, or swelling. See R. 406. Ultimately, the ALJ discounted these assertions. Ms. Steves now argues that the ALJ's rejection of this evidence was arbitrary and improper.

The ALJ's finding that Ms. Steves need not elevate her legs at chest level is supported by substantial evidence. First, the ALJ was reasonable in discrediting

Ms. Steves' own testimony regarding her limitations. Because hearing officers have the unique opportunity to evaluate a witness's forthrightness, courts generally afford such officers' credibility determinations substantial deference. *Powers v. Apfel*, 207 F.3d 431, 435 (7th Cir. 2000). A reviewing court will not set aside an ALJ's credibility finding unless it is "patently wrong." *Id.*; *Imani v. Heckler*, 797 F.2d 508, 512 (7th Cir. 1986). However, where a credibility determination is based on "objective factors or fundamental implausibilities," a reviewing court has greater freedom to review the ALJ's decision. *Herron v. Shalala*, 19 F.3d 329, 335 (7th Cir. 1994); see also *Briscoe v. Barnhart*, 425 F.3d 345, 354 (7th Cir. 2005).

The ALJ concluded that Ms. Steves' statements concerning her impairments, pain, and ability to work were not credible because the medical evidence failed to reflect objective findings that supported the degree of limitation she claimed. See R. 21. This determination was not patently wrong. The regulations provide that the ALJ will consider information submitted by the claimant or treating physician about symptom-related functional limitations and restrictions "which can reasonably be accepted as consistent with the objective medical evidence and other evidence." See 20 C.F.R. § 404.1529(c)(3). The ALJ determined that Ms. Steves' testimony about her leg elevation restriction was not consistent with the objective medical evidence.

First, the ALJ properly rejected Dr. Beaven's assertion that Ms. Steves must elevate her legs at chest level. As noted above, the opinion of a treating physician is entitled to controlling weight if it is well-supported by medically acceptable techniques and not inconsistent with other substantial evidence in the record. See 20 C.F.R. § 404.1527(d)(2). However, the Seventh Circuit has also cautioned that courts must keep in mind the potential biases that a treating physician may bring to the disability evaluation. See, *e.g.*, *Dixon v. Massanari*, 270 F.3d 1171, 1177 (7th Cir. 2001) ("The patient's regular physician may want to do a favor for a friend and client, and so the treating physician may too quickly find disability"), quoting *Stephens v. Heckler*, 766 F.2d 284, 289 (7th Cir. 1985).

In this case, the ALJ wrote that Dr. Beaven's December 29th statement "appear[ed] to be a post hearing attempt by the claimant's attorney to manufacture new evidence." R. 21. He also noted, R. 19, that Dr. Beaven had not mentioned Ms. Steves' elevation limitation in any of his treatment notes, which extended from January through October 2003. See *Smith v. Apfel*, 231 F.3d 433, 441-42 (7th Cir. 2000) (ALJ could properly consider absence of mention in treating physician's treatment notes of restrictions on claimant's functional capacity in determining weight to give treating physician's opinion); accord, *Meyers v. Barnhart*, 2005 WL 978403, *6 (W.D. Wis. Apr. 27, 2005) (absence of evidence that claimant elevated legs pursuant to any physician's recommendation would have been legitimate ground on which ALJ could have rejected such a limitation found in RFC questionnaire); cf. *Hedberg v. Barnhart*, 2003 WL 21418361, *16-17 (N.D.

Ill. Jun. 19, 2003) (remand was necessary for express finding on leg elevation when both claimant and treating physician testified about claimant's need to elevate legs for half of day, and there was no contradictory evidence in record). Further, this limitation was inconsistent with other evidence in the record, including Dr. Matibag's, Dr. Self's, and Dr. Chaudhry's treatment notes regarding Ms. Steves' swelling of her legs, as discussed above.

The ALJ also recognized that Dr. Beaven's statement afforded "no basis for concluding that this is a permanent restriction or that it is likely to continue for at least 12 months," as required by 42 U.S.C. § 423(d)(1)(A); 20 C.F.R. § 404.1509. See R. 21. And, as the Commissioner again points out, Dr. Beaven's statement does not indicate that Ms. Steves' leg elevation limitation related back to December 2002, and the disability period at issue here.

Ms. Steves points to her arteriogram results from December 19, 2003 as additional evidence of her need to elevate her legs at chest level. See Pl. Br. at 13-14. But Dr. Self's report does not support her claim. If anything, his treatment notes demonstrate that her circulation problems had improved following her angioplasty and stent treatments.

In rejecting Dr. Beaven's opinion, the ALJ did not improperly substitute his own judgment by "playing doctor" in this case. Cf. *Dixon*, 270 F.3d at 1177 ("The cases in which we have reversed because an ALJ impermissibly 'played doctor' are

ones in which the ALJ failed to address relevant evidence."); *Clifford*, 227 F.3d at 870 (ALJ may not substitute judgment for physician's opinion without relying on medical evidence in the record). Because Ms. Steves' testimony and Dr. Beaven's statement are not supported by objective medical findings, and because the ALJ discussed contradictory evidence in the record, the ALJ's determination that Ms. Steves need not elevate her legs at chest level is supported by substantial evidence.

Conclusion

The ALJ in this case found that Ms. Steves did not establish disability under the law. Because the ALJ's decision was consistent with the law and supported by substantial evidence, the court affirms the Commissioner's decision. The court will enter final judgment accordingly.

So ordered.

Date: January 9, 2006

DAVID F. HAMILTON, JUDGE
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